NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
Application for Privileges
N.J.A.C. 13:35-4A.12

OBSTETRICS AND GYNECOLOGY

Obstetrical and Gynecological Procedures:

PRIVILEGE CRITERIA

1. Attestation (Attachment 1 - in attestation format provided)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of obstetrical and gynecological procedures which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (Attachment 2A and, depending upon privileges requested, Attachments 2B and 2C)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in obstetrics and gynecology granted by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in obstetrics and gynecology, **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ **(another field) AND** active participation in examination process leading to certification in obstetrics and gynecology.

Use of Laser (Attachment 2B):

In addition to general training, for privileges for use of laser, I am providing, as **Attachment 2B**, documentary evidence of **one** of the following:

(1) Completion of a laser training program sponsored by an ACCME or AOA accredited provider of Category I CME documenting laser care, physics and clinical indications for utilization of the specific laser **and successful performance of laser procedures using the specific laser under direct clinical supervision**, or

(2) Documentation from the program director of an accredited residency training program attesting to the training in specific laser therapy during residency training.

Procedures Requiring Additional Training (Attachment 2C)

I have attached, as Attachment(s) 2C documentary evidence of the required additional training for each of the following procedures, if privileges are requested for these procedures:

Oocyte Retrieval with anesthesia services

additional training: Completion of an ACGME/AOA accredited reproductive endocrinology fellowship or equivalent training that is demonstrated by the applicant to have standards of comparable rigor in the **requested** procedure;

- Embryo Transfer with anesthesia services

additional training: Completion of an ACGME/AOA accredited reproductive endocrinology fellowship or equivalent training that is demonstrated by the applicant to have standards of comparable rigor in the **requested** procedure;

OR

Documentation from the program director of an accredited residency training program attesting to the training during residency in the **requested** procedure(s)

PLUS

Documentation from a privileged physician who has directly observed the applicant's successful performance or participation in the **requested** procedure(s).

3. Record Review/Clinical Observation:

References - Names, addresses and specialty, residency or observation only - (Attachment 3 - in format provided)

I am providing the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

A. Reference for Requested Procedure(s) requiring additional training (Attachment 3A - in format provided)

I am providing the name, address and specialty of a privileged physician who has directly observed my successful performance or participation in the **requested**

procedure(s). and whom I have asked to directly submit a reference addressing my current competence based on their personal knowledge obtained through personal observation of my successful performance or participation in the requested procedure.

4. Log of procedures (**Attachment 4A, for each privilege requested - in format provided**)

I am providing, as Attachment 4A, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding the date of the application, I performed each of the procedures for which I am requesting privileges. Each log includes a patient number, the type of anesthesia service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type of procedures for which I requested privileges will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each.

_____

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting. I have attached additional materials, including documentation of successful completion of additional training, as was noted above as Attachments 2B, 2C, and 3A, if I am requesting privileges for the specific procedure which requires additional training, including use of laser.

Requested Privileges

_____ Curettage of uterus for retained products of conception
_____ Evacuation of vulvar hematoma due to obstetrical trauma
_____ Management of fetal death
_____ Vacuum extraction for termination of pregnancy
_____ Cervical cerclage
_____ Dilatation and evacuation for termination of pregnancy

_____ Termination of pregnancy less than 14 weeks LMP

Diagnostic procedures used in evaluation of women with gynecologic or lower urinary tract conditions:

_____ Dilatation and curettage -- non-pregnant -sharp and suction
_____ Hysteroscopy - see also laser
_____ Laparoscopy - see also laser

Surgical procedures for correction of defects or treatment of conditions of the vagina, vulva and perineum:

_____ Bartholin cystectomy
_____ Excision of urethral caruncle - see also laser
_____ Hymenectomy
_____ Hymenotomy
_____ I&D Bartholin's abscess
_____ Perineorrhaphy
_____ Excision of vaginal, vulvar and perineal lesions - see also laser
_____ Anterior colporrhaphy
_____ Posterior colporrhaphy

Operative endoscopy (therapeutic):

_____ Laparoscopic procedures (specify) - see also laser
_____ Hysteroscopic ablation - see also laser
_____ Hysteroscopic polypectomy

In Vitro Fertilization:

_____ Oocyte Retrieval with anesthesia services - **Requires additional training**
_____ Embryo Transfer with anesthesia services - **Requires additional training**
_____ Other *Please specify and provide supporting documentation on a separate page:* ____

Use of Laser:

Each requires additional training in specific laser use.

_____ Hysteroscopy: NdYAG
_____ Laparoscopy: CO2, KTP, ARGON and/or NdYAG
_____ Excision of urethral caruncle: CO2
_____ Excision of vaginal, vulvar and perineal lesions: CO2
_____ Laparoscopic procedures: CO2, ARGON, NdYAG
_____ Hysteroscopic ablation: NdYAG

Please specify procedure(s) and laser (for each procedure) and provide supporting documentation on a separate page: ___

_____

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me or if the materials submitted by me are willfully false, I am subject to punishment.

_____

Signature and printed name of Applicant Date

Below this line for Administration Use Only

Application Tracking Record:

Initial Receipt Date of Application _____
Transmittal Date to Outsourcing Entity _____
Supplemental Information Requested
Supplemental Information Received _____
Outsourcing Entity Recommendation _____
Outsourcing Entity Reviewer _____
Board Committee Review Date _____
Board Disposition Date _____